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Phone: 423-307-5757
6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Gastroenterology

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

Patient Information:

Name:_____
Address:_____
City:_____State:____Zip:_____
Phone:_____Alt Phone:_____
Email:_____
DOB:_____Height:_____Weight:_____
Gender: ☐ M ☐ F Caregiver:_____

Prescriber Information:

Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____
NPI:_____DEA:_____
Tax ID:_____
Office Contact:_____Phone:_____

CLINICAL INFORMATION: **Dx (ICD-10):** ☐ **K50.90 Crohn's Disease** ☐ **K51.90 Ulcerative Colitis** ☐ **Other (ICD-10 Code):**_____

Drug Allergies:_____

Latex Allergy? ☐ **Yes** ☐ **No** **TB/PPD Test given?** ☐ **Yes** ☐ **No** **(Please send copy of results)**

Prior Failed Medications:

☐ **Methotrexate**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **Corticosteroids**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **Azathioprine**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **5-ASA (Mesalamine)**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **Sulfasalazine:**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **6-Mercaptopurine**	Length of Treatment:_____	Reason for Discontinuing:_____
☐ **Other:**_____	Length of Treatment:_____	Reason for Discontinuing:_____

PLEASE FAX COPIES: ☐ **Medical Card (Front and Back)** ☐ **Prescription Card (Front and Back)** ☐ **Clinical Notes**

INJECTION TRAINING: ☐ **Trained in Provider Office** ☐ **Manufacturer Support** ☐ **Trained by Pharmacist**

Medication	Dosage and Strength	Directions	Quantity	Refills
☐ **Cimzia®**	☐ Starter Kit 200mg/ml ☐ 200mg/ml Prefilled Syringe	☐ **Starting (Starter Kit) Dose**: Inject 400mg SC on week 0, 2 and 4 ☐ **Maintenance Dose:** Inject 400mg SC every 4 weeks	6 2	None
☐ **Entyvio™**	☐ 300mg Vials	☐ **Starting Dose:** Infuse 300mg IV over 30 minutes at day 0, day 14, and day 42 ☐ **Maintenance Dose:** Infuse 300mg IV over 30 minutes every 8 weeks	3 1	None
☐ **Humira®**	☐ Crohn's Starter Kit (3 Pens) CF ☐ 40mg/0.4ml Pen CF ☐ 40mg/0.4ml Prefilled Syringe CF	☐ **Starter Kit:** Inject 160mg (2-80mg) SC on day 1, then 80mg on day 15 ☐ **Maintenance Dose:** Inject 40mg SC every other week ☐ **Maintenance Dose:** Inject 40mg SC once a week	3 2 4	None
☐ **Remicade®**	☐ 100mg Vials	☐ **Starting Dose:** Infuse _____mg IV on day 0, day 14, and day 42 ☐ **Maintenance Dose:** Infuse _____mg IV every 8 weeks		None
☐ **Rinvoq®**	☐ 15mg Tablets ☐ 30mg Tablets ☐ 45mg Tablets	☐ **Induction Dose:** Take 45mg PO once daily for 8 weeks ☐ **Maintenance Dose:** Take 15mg PO once daily ☐ **Maintenance Dose:** Take 30mg PO once daily	30 30 30	None
☐ **Simponi®**	☐ 100mg/ml Smartject Autoinjector ☐ 100mg/ml Prefilled Syringe	☐ **Starting Dose:** Inject 200mg SC at week 0, then 100mg on week 2 ☐ **Maintenance Dose:** Inject 100mg SC every 4 weeks	3 1	None
☐ **Skyrizi®**	☐ 600mg/10ml Vial ☐ 180mg/1.2ml Prefilled Cartridge ☐ 360mg/2.4ml Prefilled Cartridge	☐ **Induction Dose:** Infuse 600mg IV at Week 0, Week 4 and Week 8 ☐ **Maintenance Dose:** Inject 180mg SC at Week 12 and every 8 weeks thereafter ☐ **Maintenance Dose:** Inject 360mg SC at Week 12 and every 8 weeks thereafter	3 1 1	None
☐ **Stelara®**	☐ 130mg Vials ☐ Up to 55kg ☐ >55kg to 85kg ☐ >85kg ☐ 90mg Prefilled Syringe	☐ **Starting Dose:** Infuse 260mg (2 vials) IV as a single dose at week 0 Infuse 390mg (3 vials) IV as a single dose at week 0 Infuse 520mg (4 vials) IV as a single dose at week 0 ☐ **Maintenance: Dose** Inject 90mg SC 8 weeks after initial infusion then every 8 weeks thereafter	2 3 4 1	None None None
☐ **Xeljanz®** ☐ **Xeljanz XR®**	☐ 5mg Tablets ☐ 10mg Tablets ☐ 11mg XR Tablets ☐ 22mg XR Tablets	☐ **Induction Dose:** Take 10mg PO twice daily for 8 weeks or _____ weeks ☐ **Maintenance Dose:** Take 5mg PO twice daily ☐ **Induction Dose:** Take 22mg XR PO once daily for 8 weeks or _____ weeks ☐ **Maintenance Dose:** Take 11mg XR PO once daily	60 60 30 30	None None
☐ **Other**				

By signing this form and utilizing our services, you are authorizing FountainRx and/or its designee to serve as your prior authorization designated agent in dealing with medical and prescription insurance compa-nies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature:_____ **Date:**_____